Prescription Drug Reimbursement Form

See the back for instructions. Complete all information.
An incomplete form may delay your reimbursement.

PAID Prescriptions, L.L.C.

Member/Subscriber Information *See your Member ID card.*

Group No. ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member ID ☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐☐

Member Name (First, Last)

Street Address

City ☐☐ State ☐☐☐☐☐ Zip

Patient Information

Patient Name (First, Last)

Patient Date of Birth (Month/Day/Year) ☐☐ ☐☐ ☐☐☐☐

Sex

☐ Female
☐ Male

Relation to Plan member

☐ 1 Self
☐ 2 Spouse
☐ 3 Eligible Child
☐ 4 Dependent Student
☐ 5 Disabled Dependent
☐ 6 Dependent Parent
☐ 7 Other
☐ 8 Non-spouse Partner

Pharmacy Information

Name of Pharmacy

Street Address

City ☐☐ State ☐☐☐☐☐ Zip

Telephone (include area code) ☐☐☐ ☐☐☐ ☐☐☐☐

Is this an on-site nursing home pharmacy? ☐Yes ☐ No

I hereby certify that the charge(s) shown for the medications prescribed is (are) correct and agree to provide PAID Prescriptions or its agents reasonable access to records related to medication dispensed to this patient in accordance with applicable law. I further recognize that reimbursement will be paid directly to the Plan member and assignment of these benefits to a pharmacy or otherwise is void.

X _____ _____

Signature of Pharmacist or Representative **(Required)** — **NABP Number Required**

Claim Receipts

Tape claim receipts or itemized bills on the back. **Do not staple!**

Check the appropriate box if any of the receipts are for a medication that:

☐ **is a compound prescription.**
If so, make sure your pharmacist lists all the ingredients and quantities on the receipt.

☐ **was purchased outside the U.S.A.**
If so, please indicate:

Country _____

Currency used _____

☐ **is for treatment of an allergy.**

Please tape receipts on the back

Acknowledgment

I certify that the medication(s) described above was received for use by the patient listed above, and that I (and the patient, if not myself) am/are eligible for drug benefits. I also certify that the medication received was not for an on-the-job injury or covered under another benefit plan. I authorize the release of all information to the plan administrator, underwriter, sponsor, policyholder, employer, and their agents for use in connection with the benefit plan programs. This information may also be used for other reporting and analysis purposes without identification of me or my family members. I further authorize the use of my Social Security Number for identification purposes. I recognize that reimbursement will be paid directly to me, and that assignment of these benefits to a pharmacy or any other party is void.

X _____

Signature of Member

Claim Receipts

Please tape your receipts here. **Do not staple!**

Tape receipt for Rx 1 here

Tape receipt for Rx 2 here

Receipts must contain the following information:

- Date prescription filled
- Name and address of pharmacy
- Doctor name or ID number
- NDC number (Drug number)
- Name of drug and strength
- Quantity and days' supply
- Prescription number (Rx number)
- DAW (Dispense As Written)
- Amount paid

Tape receipt for Rx 3 here

Tape receipt for Rx 4 here